Chapter 5
Hospice Services

Maryland Hospice Services: Overview and Definition

According to the National Hospice Organization ("NHO"), hospice is an organized program that, upon informed choice, "provides palliative care to terminally ill patients, and supportive services to patients, their families, and significant others, twenty-four hours a day, seven days a week, in both home and facility-based settings. Physical, social, spiritual, and emotional care is provided during the last stages of illness, during the dying process, and during bereavement by a medically directed interdisciplinary team consisting of patient, families, professionals and volunteers."[114]

Hospice care programs are licensed in Maryland as either general hospice programs or as limited hospice programs under Health-General Article §19-901 through §19-913. A *general* hospice care program is defined as "a coordinated, interdisciplinary program of hospice care services for meeting the special, physical, psychological, spiritual, and social needs of dying individuals and their families by providing palliative and supportive medical, nursing and other health services through home or inpatient care during illness and bereavement to individuals who have no reasonable prospect of cure, as estimated by a physician, and to the families of those individuals." A general hospice care program may provide services in a home-based setting or in a variety of inpatient health care facilities. *Limited* hospice care programs provide palliative and supportive non-skilled services through a home-based hospice care program only, obtaining palliative and supportive medical, nursing and other health services by referral

Supply and Distribution of Hospice Services

In 1999, there were 33 hospices licensed to provide care in Maryland. Of the 33 licensed hospice programs, 29 have general licenses, and 4 have limited hospice licenses (Hospice Caring, Inc., Kent Hospice Foundation, Caroline Hospice Foundation, and Talbot Hospice Foundation).[115]

Until last year, there were three hospices in Maryland with inpatient hospice beds. These Baltimore City hospices were Joseph Richey House (20 beds), Hospice of Baltimore (24 beds) and Stella Maris Hospice (39 beds). In May 1999, Montgomery Hospice completed construction of an inpatient hospice facility, the Casey House, in Rockville, Maryland. Currently, it maintains 14 beds (7 acute and 7 residential) in which it provides varying

[114] National Hospice Organization. Website:http://www.nho.org/proappdl2.htm

[115] Hospice Network of Maryland, *1999 Annual Survey*, June 14, 2000.

levels of palliative care and pain management.

In addition to these facilities dedicated to hospice care, many hospitals and nursing homes make beds available on a case-by-case basis for respite care and complex pain or symptom management of hospice patients. Typically, the facility reaches a contractual agreement with licensed hospice care programs to provide care in the inpatient setting. The Commission may receive notice that the arrangements have been made, as in December 1996 when Mercy Medical Center set aside five comprehensive care beds for hospice care and in March 2000 when Northwest Hospital Center designated two of its subacute beds for hospice patients from VNA Hospice of Maryland and Mid-Atlantic (now Heartland) Hospice. More frequently, anecdotal reports note instances where nursing homes, in particular, make beds available for this purpose. Recently, the Health Services Cost Review Commission ("HSCRC") reviewed its policy on setting rates for hospice care provided at hospitals, such as aggressive pain management.

More of Maryland hospices are nonprofit and more are Medicare certified than is reported nationally. Of the 33 hospices in Maryland, there are only five for profit hospices: Hospice of Maryland, Helix Home Health Hospice, VNA of Maryland, Mid Atlantic Hospice and HomeCall Hospice.[116]

Each hospice may serve clients in one or more jurisdictions depending on the terms of its CON approval, or for an older agency, its grandfathering in the 1980's. Table 5-1 shows hospice agencies and number of clients by jurisdiction in 1997 and 1999.

[116] Ibid.

Table 5-1
Number of Hospice Clients and Agencies by Jurisdiction:
Maryland, Fiscal Years 1997 and 1999

Jurisdiction of Client Residence	1997		1999		Percent Change	
	Number of Clients	Number of Hospice Programs Serving Jurisdiction	Number of Clients	Number of Hospice Programs Serving Jurisdiction	Number of Clients	Number of Hospice Programs Serving Jurisdiction
Allegany County	369	1	164	1	-56%	0%
Carroll County	241	6	291	9	21%	50%
Frederick County	315	3	313	3	-1%	0%
Garrett County	65	1	81	1	25%	0%
Washington County	201	1	194	2	-3%	100%
Western Maryland Total	**1,191**		**1,043**		**-12%**	
Montgomery County	1,162	7	1,066	9	-8%	29%
Montgomery County Total	**1,162**		**1,066**		**-8%**	
Calvert County	110	1	127	2	15%	100%
Charles County	179	1	218	1	22%	0%
Prince George's County	830	5	805	8	-3%	60%
St. Mary's County	145	1	146	1	1%	0%
Southern Maryland Total	**1,264**		**1,296**		**3%**	
Anne Arundel County	808	9	862	10	7%	11%
Baltimore County	1,402	12	2,199	10	57%	-17%
Baltimore City	1,312	11	1,483	11	13%	0%
Harford County	351	10	338	8	-4%	-20%
Howard County	272	9	434	8	60%	-11%
Central Maryland Total	**4,145**		**5,316**		**28%**	
Caroline County	83	3	40	1	-52%	-67%
Cecil County	89	3	204	4	129%	33%
Dorchester County	72	1	66	1	-8%	0%
Kent County	98	3	57	1	-42%	-67%
Queen Anne's County	106	4	121	2	14%	-50%
Somerset County	52	1	48	1	-8%	0%
Talbot County	43	2	79	2	84%	0%
Wicomico County	179	1	195	1	9%	0%
Worcester County	94	1	123	2	31%	100%
Eastern Shore Total	**816**		**933**		**14%**	
Maryland Total	**8,578**		**9,654**		**13%**	

Source: Data for 1997 is from the Maryland Health Care Commission, *Hospice Trends and Projected Future Needs in Maryland: 2002*, June 1999; data for 1999 reflects unpublished data reported to the Hospice Network of Maryland on origin of patients served in 1999. The data reflects areas where service was actually provided during the reporting period.

As shown in Table 5-1, the total number of hospice clients in 1997 was 8,578. By 1999, the number had increased 13 percent to 9,654. During the same period, the number of hospices increased by 2 percent. Since the table reflects data voluntarily reported to the Hospice Network of Maryland, the completeness and quality of the data may vary from agency to agency and from year to year.

There was a noticeable difference in the number of clients served in Cecil County during the two reporting periods. In 1997, only 89 patients were served in Cecil County. In 1999, the number had changed to 204 patients--an increase of 129 percent. At the same time, the number of hospices for this county increased from 3 to 4. Allegany County showed the greatest decrease in the number of hospice clients served. In 1997, Allegany County provided care to 369 patients. By 1999, the number of patients served decreased by 56 percent.

Trends in the Utilization of Hospice Services

As previously discussed, the number of Maryland hospice clients increased from 8,578 to 9,654 between 1997 and 1999. Tables 5-2 and 5-3 illustrate various trends in hospice services such as percentage changes in race, age, cause of death, and average length of stay.[117]

[117] The tables reflect voluntary information reported to the Hospice Network of Maryland. As such, the completeness and quality of data vary from agency to agency and from year to year.

Table 5-2
Trends in Hospice Utilization:
Maryland Selected Years, 1987-1999

Data	**1987**	**1991**	**1993**	**1995**	**1997**	**1999**
#Hospices Reporting	32	30	35	38	34	31
Members Network	32	32	37	40	35	26
Medicare Certified	28%	65%	73%	82%	80%	87%
Age						
65+ years	67%	61%	68%	67%	71%	73%
45-64 years	29%	39%	23%	24%	22%	22%
18-44 years	4%	-	8%	9%	6%	4%
0-17 years	<1%	<1%	<1%	<1%	<1%	<1%
Race						
Caucasian	85%	83%	77%	76%	77%	74%
African American	14%	15%	18%	21%	18%	17%
Hispanic/Asian	1%	1%	1%	<1%	<1%	1%
Other	-	<1%	4%	3%	4%	8%
Sex						
Male	50%	48%	51%	51%	48%	46%
Female	50%	52%	49%	49%	52%	54%
Cause of Death						
Cancer	92%	87%	83%	78%	67%	67%
Circulatory	<1%	-	-	6%	8%	9%
Respiratory	2%	-	-	4%	5%	6%
AIDS	<1%	3%	5%	5%	3%	1%
Dementia	-	-	-	-	4%	7%
Other	4.4%	-	6%	8%	13%	6%

*Note: For 1987-1991, age breakdown was <21,21-40,41-64,65+
Source: Hospice Network of Maryland Surveys, selected years 1987-1999.

Table 5-3
Comparison of Selected Hospice Characteristics:
Maryland vs. U.S., 1996[118]

Data	Maryland	United States
Average Length of Stay	47.8 days	61.5 days
% Home Care	96%	90%
% Died at Home	69%	77%
Cause of Death		
Cancer	74%	60%
AIDS	6%	4%
Circulatory/Respiratory	10%	-
Alzheimer's/Dementia	2%	2%
Heart	-	6%
Renal	3%	1%
Other	6%	25%
Source of Payment		
Medicare	70%	65%
Private Insurance	-	12%
Medicaid	7%	8%
Nonreimbursed	<1%	4%
Other	23%	11%
Sex		
Male	49%	52%
Female	51%	48%
Race		
Caucasian	74%	83%
African American	21%	8%
Hispanic	<1%	3%
Other	6%	6%
Sponsorship		
Nonprofit	87%	65%
For Profit	9%	16%
Government	3%	4%
Other	-	15%
Medicare Certified	88%	80%

Notes: Average Length of Stay is for general licensed hospice programs.
Source: Hospice Fact Sheet, 1998 and Hospice Network of Maryland Survey

[118] The National Hospice & Palliative Care Organization compiles national figures every three years. Beginning with 1999 data that should be available by the end of 2000, the Organization plans to analyze data on a yearly basis.

- **Age**

Data collected by the Hospice Network of Maryland indicates that the majority of patients who utilize hospice services are 65 and older. In 1987, 67 percent fell into this age group. By 1999, 73 percent of patients utilizing Maryland hospice services were 65 and over.

Although older Americans are living longer and living better than in previous years, many of those age 65 and older face disability, chronic health conditions, or memory impairments. In the United States, the population age 65 and older is expected to double by 2030. Americans born at the beginning of the 21st century are expected to live almost 30 years longer than those born at the turn of the 20th century. In 1997, a newborn baby girl could expect to live 79 years compared to only 51 years in 1900. Similarly, a newborn baby boy born in 1997 could expect to live 74 years, while life expectancy in 1900 was only 48 years. Since life expectancy varies by race, the average life expectancy for a white baby born in 1997 was six years higher than for an African American baby born in the same year. [119]

Figures from the Hospice Network of Maryland reveal that the percent of patients in the 0-17 age group who received hospice care remained less than 1 percent from 1987 to 1999. Because a child's death is difficult to contemplate, only 10 percent of hospice programs nationwide accept children. In Maryland, it is estimated that fewer than one dozen licensed programs take children.[120]

- **Cause of Death**

Available data suggest that the proportion of cancer as the presenting diagnosis is decreasing in hospice care. In 1987, 92 percent of patients served by Maryland hospice programs listed cancer as the cause of death. By 1999, cancer was reported as the cause of death in only 67 percent of the hospice population. As reflected in data reported by the Hospice Network of Maryland, diagnoses in circulatory disease, respiratory problems, and dementia are increasing.

In 1997, the leading cause of death among Americans age 65 or older was heart disease (1,832 deaths per 100,000 persons), followed by cancer (1,133 per 100,000), stroke (426 per 100,000), chronic obstructive pulmonary diseases (281 per 100,000), pneumonia and influenza (237 per 100,000), and diabetes (141 per 100,000). [121] In 1998, the leading cause of death among Marylanders age 65 or older was heart disease (32 percent), followed by cancer (23.5 percent), stroke (7.5 percent), chronic obstructive pulmonary diseases (5.0 percent), pneumonia and influenza (4.9 percent), and diabetes (3.6 percent).[122]

[119] Press Release, Federal Interagency Forum of Aging, *Well-Being Improves for Most Older People, But Not for All, New Federal Report Says*, August 10, 2000.

[120] "Hospice for Children" *The Sun*, August 28, 2000.

[121] Refer to the Commission's *An Analysis and Evaluation of Certificate of Need Regulation in Maryland-Working Paper: Hospice Services*, September 15, 2000, Appendix B for data on leading causes of death by sex and race.

[122] Division of Health Statistics, *Maryland Vital Statistics Annual Report,* 1998.

Whether an illness is "terminal" and when a patient will die are difficult to diagnose. However, for reimbursement eligibility, Medicare/Medicaid coverage of hospice care depends upon a physician's certification of an individual's prognosis of a life expectancy of six months or less if the disease takes its usual course. Even though the course of most advanced malignancies may be more predictable than that of other non-cancer illnesses, errors in prognosis occur, usually in overestimating life expectancy. This tendency to overestimate life expectancy may in part explain why a large number of patients are referred to hospices in the final hours or days of life, when hospice care is unlikely to significantly benefit the patient and family.[123]

Determining a prognosis in illnesses such as end-stage lung disease or Amyotrophic Lateral Sclerosis ("ALS") can be difficult. The history of most non-cancer diseases is often characterized by periods of stability rather than the steady decline more common in cancer. With this in mind, the National Hospice Organization recently published *Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases* as a tool for hospice programs evaluating patients. The book is a resource for hospice programs when evaluating patients for admission and re-certification.

- **Average Length of Stay**

Hospices in Maryland experience a shorter average length of stay ("LOS") than nationally. In 1996, the average length of stay in Maryland was 47.8 days. Nationally, the average length of stay was 61.5 days. In Maryland, 96 percent of patients receive hospice services at home as opposed to 90 percent of patients nationally.

Research has suggested that there are differences between LOS in rural communities and LOS in urban areas. A recent study investigated the relationship between LOS and several factors in a small, rural hospice and found significant differences in LOS by primary physician specialty, referral source, and diagnosis. A subsequent study replicated and extended the study in a mid-sized, urban hospice setting and examined the relationship of LOS with additional variables, such as living status, discharge status, race, and religion. Significant differences in LOS by gender, diagnosis, physician specialty, referral source, type of insurance, living status, and discharge status were found. No significant differences in LOS were found by race, religion, and place of death.[124] While further studies are needed, one factor that may contribute to the differences observed in LOS is differences in access to the latest information regarding pain management thereby affecting a patient's length of stay.[125]

[123] Cancer Control Journal, *Overview of Hospice and Palliataive Care in Oncology*, Ronald S. Schonwetter, M.D., Vol. 3, No. 3, May/June 1996.

[124] The American Journal of Hospice and Palliative Care, *Factors Associated with Length of Stay in a Mid-sized, Urban Hospice*, Marla J. Somova, MS; Pavel G. Somov, MS; Jenifer C. Lawrence, MS; Thomas T. Frantz, Ph.D. March/April 2000.

[125] Hearing Before the Subcommittee on the Constitution of the Committee of the Judiciary House of Representatives, *Pain Relief Promotion Act of 1999*, June 24, 1999.

- **Utilization by Minorities**

Increasing proportions of African Americans in Maryland are using hospice services. Usage rose steadily from 14 percent in 1987 to 21 percent in 1995. Although the figure decreased in 1997, the table reflects an overall increase. Additionally, a greater proportion of African Americans receive hospice care in Maryland than for the U.S.

Despite this overall increase in access experienced in Maryland, studies have suggested that ethnic minorities as well as those without stable home environments are often medically underserved because they tend to think of palliative care as giving up hope.[126] Views regarding death and dying are not shared by all cultures. Specifically, according to data reported in *The Washington Post*, African Americans are less likely to prepare a living will, talk to a doctor about end-of-life care, or participate in a hospice program. When death is inevitable and imminent, African Americans are twice as likely as Caucasians to request life sustaining treatments. Many African Americans do not see palliative and hospice care as offering better care at the end of life. Some patients worry that palliative treatment is actually synonymous with "no care" or "less care."[127]

- **Hospice Volunteers**

Hospice, which originated in the 1970s as a voluntary organization located solely within the private sector, is now a mainstream care option with professional staff supported partially by public dollars.[128] The movement away from less private funding was triggered by the 1983 federal legislation granting Medicare reimbursement for hospice services. Over the years, as the patient population grew, aggregate levels of volunteers and professional staff increased. However, ratios of professional staff and volunteers to patients reveal that regardless of certification status, hospices retain more professional staff per patient and fewer volunteers per patient over time. This suggests that hospices, particularly certified organizations, have transitioned from voluntary organizations to professionally staffed organizations with a strong volunteer component and that the evolution continues over time, in each program.[129]

Table 5-4 illustrates the hospice volunteer component according to data reported to the Hospice Network of Maryland. It should be pointed out that the number of hospices responding to the survey was less in 1999 than in 1997, which likely contributed to the reported decrease in the total number of volunteers:

[126] Hospice Journal, *Issues of Access in a Diverse Society*, 12(2):9-16, 1997.
[127] "At the End of Life, Color Still Divides, *The Washington Post*, February 15, 2000.
[128] The Hospice Journal, *The Evolution of Volunteerism and Professional Staff Within Hospice Care in North Carolina*, Vol. 15(1) 2000.
[129] Ibid.

Table 5-4
Hospice Volunteer Data: Maryland, 1997-1999

	1997	1999	Change 1997 from 1999
Total Number of Volunteers	4,662	3,576	-23%
Volunteer Hours Donated	159,796	159,170	0%
Volunteer Cost Savings	$2,115,709.23	$2,276,131.43	8%
Hospices Responding to Survey	34	31	-9%

Source: Hospice Network of Maryland Annual Surveys

As the table reveals, the total number of hospice volunteers decreased by 23 percent between 1997 and 1999, however, the number of volunteer hours donated remained approximately the same. There was an 8 percent increase in the volunteer cost savings, reflecting increase in the hourly valuation of volunteer time.

A mid-nineties National Hospice Organization survey of volunteerism found that more than 95,000 volunteers provided more than 5.25 million hours of service in one year. Of these volunteers, approximately 75,000 were female and approximately 21,000 were male. Characteristics of hospice volunteers reveal that they are a loyal group with the average volunteer remaining approximately three years with hospice. Fifty percent of volunteers stay six years or more. Volunteers come to hospice for a number of reasons and with various skills. The hours they spend as volunteers touch patients and families in many ways such as providing a needed break to caregivers, providing meals, and transporting patients to medical appointments. As Iowa hospice volunteer Ellie Garret described her experience, "I became a part of that family, where I felt cherished, and very, very necessary. And that, my friends, is what being a hospice volunteer is all about."[130]

Quality Issues

Most patients who die without hospice care experience poor pain control because their health care providers have limited knowledge of opiate pharmacology, poor pain assessment skills, or a reluctance to prescribe narcotics. Communication with patients about pain tends to be inadequate, and many providers fear governmental oversight and restrictions related to prescribing controlled substances.[131]

Hospice health care providers must meet the challenge of providing palliative care in the face of little existing knowledge and research to guide the management of physiological and psychological needs of dying patients and their families. Terminal illness affects the patient on several levels,

[130] Volunteering at Hospice: 2000. Website:http: //www.iowacityhospice.com/ichvol.html
[131] Ibid.

including social, psychological and spiritual. The psychologic vulnerability of the dying person is a major focus of palliative care.[132]

In Maryland, there is an effort underway to improve hospice care in nursing homes. The Faculty Scholars Program of the Project on Death in America of the Open Society Institute is engaged in a project to improve end of life care in Maryland nursing homes.[133] According to research by Dr. Timothy Keay, current research indicates that hospice is underutilized in nursing homes. "When hospice services are utilized, dying residents have less pain, less agitation, less dyspnea (shortness of breath), and are noted to have bereavement addressed and are far more frequently noted to be comfortable at the time of death."[134]

Other measures are being taking to promote better knowledge of hospice. The federal Office of the Inspector General ("OIG") launched Operation Restore Trust in order to examine issues of Medicare fraud and abuse focusing on several health care areas, including hospice services. The investigation focused on 12 selected large hospice providers in the continental U.S. that had higher than average numbers of long-term patients. Project Operation Restore Trust focused on five states that accounted for 40 percent of total Medicare expenditures and beneficiaries (California, Florida, Illinois, New York and Texas).

The investigation revealed that, overall, hospice is working well. Care plans were developed for 96 percent of the beneficiaries. And, in 99 percent of the patient records reviewed by the contractors' physician, documentation showed that beneficiaries and their families received services indicated by the plan of care.[135]

Cost of Hospice Services

Reimbursement for hospice services comes from Medicare, Medicaid, health maintenance organizations and other private insurance plans. The Federal and State governments have specific standards of care written into the law to protect consumers. Federally recognized hospice care in the United States began with the implementation of parts of the Social Security Act. Most third-party payers reimburse hospice care programs. While relatively little is known about the structure and administration of hospice benefits within commercial insurance plans, approximately 80-90 percent of hospice care is provided in the Routine Home Care component.[136]

- **Medicare Reimbursement**

In 1983, Congress expanded the Medicare insurance program to include hospice care. Hospice care can be accessed under the

[132] The Hospice Journal, *Assessing Readiness for Death in Hospice Elders and Older Adults*, Vol. 15(2) 2000.
[133] Maryland Health Resources Planning Commission, *Hospice Trends and Projected Future Needs in Maryland: 2002*, June 1999.
[134] Information supplied by Dr. Timothy Keay, University of Maryland School of Medicine, February 3, 1999; unpublished research.
[135] The MEDSTAT Group, *Important Questions for Hospice in the Next Century*, March 2000, P. 21.
[136] The MEDSTAT Group, *Important Questions for Hospice in the Next Century*, March 2000, P. 12.

regular Medicare benefit, covered under Medicare Part A (Hospital Insurance). An individual may qualify for Medicare coverage at the age of retirement (65) if he or she has contributed 40 quarters of payroll taxes toward Part A, hospital insurance through payroll deductions. In addition, if an individual qualifies for SSDI, he or she may qualify for Medicare Coverage as well but must be disabled for two years before Medicare goes into effect.

Medicare requires hospice care programs to be Medicare-certified and to be licensed (in states that license hospice care programs) before it will reimburse for services. A hospice must meet "Conditions of Participation" to become licensed and certified by state regulators and to be allowed by HCFA to continue to participate in the Medicare hospice program. Without certification of their compliance with these standards, hospices cannot receive reimbursement from Medicare or Medicaid for patients enrolled in their program. The "Conditions of Participation" generally cover:

General Provisions and Administration – These subregulations outline the structure of the hospice and the general administration of the program including quality assurance, ability to pay, use of volunteers, and maintenance of clinical records, care, continuation of care irrespective of ability to pay, inservice training, quality assurance, interdisciplinary groups, volunteers, licensure requirements, and maintenance of clinical records.

Core Services – These sub-regulations cover the provision of core services that must be routinely provided directly by hospice employees. These core services are nursing, physician, medical social work and counseling services, including bereavement. A hospice may use contracted staff, if necessary but must maintain the professional, financial, and administrative responsibility for the services.

Other Services – These sub-regulations cover the nature of other services that may be provided – therapies (physical, occupational and speech-language pathology), lab tests, medical supplies, home health aide or homemaker and short-term inpatient care.

Medicare coverage is available for hospice care if:

- The patient is eligible for Medicare Part A;
- The patient's doctor and the hospice medical director certify that the patient is terminally ill with a life expectancy of six months or less;
- The patient signs a statement choosing hospice care instead of standard Medicare benefits for the terminal illness; and
- The patient receives care from a Medicare-approved hospice program.

The Medicare hospice benefit is fairly all-inclusive with the patient's responsibility limited to cost sharing for outpatient drugs and inpatient respite care.

Certain specified benefit periods apply to Medicare coverage of hospice care. A Medicare beneficiary may elect to receive

hospice care for two 90-day benefit periods, followed by an unlimited number of 60-day periods. The benefit periods may be used consecutively or at intervals. A physician must certify that the patient is terminally ill at the beginning of each period. The patient signs an elective statement indicating that he or she understands the nature of the illness and of hospice care. A patient has the right to cancel hospice care at any time and return to standard Medicare coverage then later re-elect the hospice benefit. If a patient cancels hospice during one of the benefit periods, any days left in that period are lost. However, the patient is still eligible for the second 90-day period and the unlimited number of 60-day periods. Besides having the right to discontinue hospice care at any time, patients also may change hospice programs once each benefit period.[137] In addition to hospice services, the patient may continue to receive Medicare benefits not related to the terminal illness.

The reimbursement for Medicare reimbursement is classified into the following four components. National hospice rates for care and services furnished on or after October 1, 2000 through September 30, 2001, before area wage adjustments, are also shown:

◄ **Routine Home Care**

This is the basic and most frequently delivered level of hospice care. This is hospice care at home for an individual who is not receiving continuous nursing care. In addition, care provided by hospices to Medicare beneficiaries who reside in long term care (LTC) facilities is also classified by Medicare as routine home care. (FY2001 - $101.84 per day.)

◄ **Continuous Home Care**

This level is usually related to the development of acute medical symptoms in a patient who wishes to stay home but requires more extensive care than provided in routine home care. Continuous home care must be provided a minimum of eight hours/day and is primarily, although not exclusively, nursing care. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill patient at home. (FY2001 - $594.41 Full Rate-24 Hours of Care/$24.77 Hourly Rate.)

◄ **Inpatient Care**

For the care of pain or other symptoms (acute or chronic) that cannot be managed at home, hospices must have the availability of inpatient care. Such inpatient care can be provided in a stand-alone hospice facility, a dedicated hospice wing/unit in a hospital or Skilled Nursing Facility/long term care facility, or "contract beds" within a hospital or SNF or LTC facility. (FY2001 - $453.04 per day.)

[137] Maryland Health Resources Planning Commission, *Hospice Trends and Projected Future Needs in Maryland: 2002*, June 1999.

◄ Respite Care

Limited to five consecutive days, respite care provides a brief break for the primary caregiver by admitting the hospice patient to an institutional setting on a short-term basis. In addition to providing the caregiver relief in the daily caring of the patient, respite care provides an alternative environment for care if the patient's home is temporarily inadequate to met the patient's care needs. (FY2001 - $105.35 per day.)

- **Medicaid Reimbursement**

The Maryland Medicaid Program offers a hospice benefit virtually identical to that of Medicare. In order to receive payment under Medicaid, a hospice must meet the Medicare conditions of participation applicable to hospices, and have a valid provider agreement with HCFA. Individuals eligible for Medicaid may reside in a nursing facility and receive hospice care in that setting.

One condition of Medicaid coverage is the establishing of a plan of care before services are provided. In general, services must be related to the palliation or management of the patient's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills

Hospice care rendered in an individual's home is paid based upon either a routine home care day rate or a continuous home care day rate. Before enactment of the Balanced Budget Act of 1997 ("BBA"), adjustments to the wage component of these rates were made according to the location of the administrative office of the hospice. Under the BBA, hospices are required to submit claims for payment for hospice care furnished in an individual's home based upon where care is actually provided. To satisfy this requirement, hospice providers must identify (in the Medicaid claim) the geographic location of the home in which the hospice care is furnished. This information will be a determining factor in defining the rate of payment.[138]

Nationally, in comparison to hospital and skilled nursing facilities costs, hospice appears to be a cost-effective service. Table 5-5 provides a comparison of the average cost for a Medicare patient to stay one day in a hospital, a skilled nursing facility and a hospice. Hospice charges per day are substantially lower than the hospital and skilled nursing facility charges per day. Much of the savings from hospice care relative to conventional care accrue in the last month of life. Primarily, this is due to the substitution of home care days for inpatient days during this period. [139] Cost-effectiveness, however, is not the only basis for hospice care. Hospice is a humane and compassionate way to deliver health care and supportive services. It allows terminally ill patients and their families to remain together in comfort and dignity and allows family members to take an active role in supplementing the care given by formal caregivers.[140]

[138] Health Care Financing Administration, *State Medicaid Director Letter*, August 18, 1998.
[139] NAHC, *Basic Statistics About Hospice*, October 1999, P. 12.
[140] Ibid.

Table 5-5
Comparison of Hospital, SNF and Hospice Medicaid Charges: 1995-1998

	1995	1996	1997	1998
Hospital Inpatient Charges Per Day	$1,909	$2,068	$2,238	$2,177
Skilled Nursing Facility Charges Per Day	$402	$443	$487	$482
Hospice Charges Per Covered Day of Care	$103	$106	$109	$113

Sources: The 1995, 1996 and 1997 hospital and SNF Medicare charge data are from the Annual Statistical Supplement, 1998, to the Social Security Bulletin, Social Security Administration (November 1998). The 1995 and 1996 hospice charge data are from the Health Care Financing Review, Statistical Supplement, Health Care Financing Administration, 1997 and 1998, respectively.
Note: Additional years are projected using consumer price index forecasts from the Bureau of Labor Statistics web site.

Future Utilization of Hospice Services

Under Maryland health planning law, the establishment of hospice services requires CON approval. To guide the review of proposed new services and the development of any needed new capacity, the Commission's State Health Plan ("SHP") contains planning policies, a need projection, and criteria and standards for reviewing CON applications.

There are several factors that affect the current utilization and future growth of hospice care both nationally and in Maryland. For example, some people question whether hospice providers have become the victims of their own success due to the growth of hospice care. With for-profit hospices developing their markets, many traditional hospice providers find themselves in an unfamiliar situation in competition with other, often larger providers of hospice care. There is also a need for public education about hospice. Even though the medical professions and the public are both increasingly aware of the benefits of hospice care, there is continued reluctance to face the issues of death and dying. Persons usually put off hospice care for as long as possible. While hospice care does not hasten death, it does make the inevitable more comfortable for the patient and family.

- **Task Force to Conquer Cancer in Maryland**

A special task force is addressing various factors relating to the current utilization and future growth of hospice regarding cancer. In 1999, in response to the tobacco litigation settlement, the Maryland General Assembly established a Cigarette Restitution Fund to provide for the distribution of funds from the settlement (Chapter 173). That same year, Governor Glendening announced a 10-year vision for the use of the tobacco settlement funds and appointed three task forces, including the Task Force to Conquer Cancer in Maryland. One objective of the Task Force is to provide 20 percent of the funds set aside for "Treatment/Supportive Care" funding ($4 Million) for cancer

support services such as transportation, case management, cancer support groups, and hospice care.[141]

The overall objective of the Task Force is to determine how best to combat cancer in Maryland and to make recommendations on how to allocate $50 million from the tobacco settlement fund for each of the years. The Task Force developed a series of ten-year goals, objectives and recommendations in four primary areas: prevention/early detection, education, treatment/supportive care and research. With regard to hospice services, the Task Force is focusing on the need to provide more psychosocial and emotional support services for hospice care and pain management, as well as narrowing gaps in support services. The issues will be approached in various ways such as through the media, public service announcements, and health professionals, in order to promote knowledge and reduce barriers to cancer care.[142]

- **Pediatric Hospice Services**

Another area of concern regarding future utilization of hospice services is that of pediatric services. Out of 2,500 hospice programs nationwide, only about 250 are for children. Data collected by the Hospice Network of Maryland indicate that the percent of patients in the 0-17 age group remained less than 1 percent from 1987 to 1999. Because few such programs exist for the 53,000 U.S. youngsters who die each year, the American Academy of Pediatrics recently issued its first recommendation that comprehensive, hospice-like treatment designed to improve the quality of life for children with life-threatening or terminal illnesses be made widely available. Additionally, last year Congress appropriated $1 million to the Children's Hospice International, a suburban Washington-based advocacy group that provides palliative care for children. The appropriation was to "incorporate hospice care into health care from the time of diagnosis."[143]

- **Home-Based Telemedicine Systems**

Technological advances are suggesting further changes in the utilization of hospice services. In 1998, a pilot study of telenursing for terminally ill patients at home was launched between the University of Kansas Medical Center and the Kendallwood Hospice. Using the public telephone network, interactive video equipment was installed in the homes of three nurses who received after-hours calls and in the homes of six hospice patients living in either Kansas or Missouri. Data concerning the utilization patterns were gathered for two separate three-month periods and both patients and caregivers reported general satisfaction with the telehospice system. In another area of the study, expenses were monitored for the traditional (in-person) and telehospice visits. For traditional care, the cost per visit was $126 and $141, for the first and second time periods, respectively. The average

[141] *Report of the Governor's Task Force to Conquer Cancer in Maryland*, December 9, 1999, p7.
[142] Ibid., p.38.
[143] "Doctors Seek 'Comfort' Care for Terminally Ill Kids." *The Sun,* August 8, 2000.

telehospice visit cost was $29.[144] The use of hospice care via home-based telemedicine systems is being considered as a method of reaching rural patients who are living far from a base station. Additionally, it is being tested in some urban areas where nighttime nursing visits raise safety concerns.[145]

Although this study suggests that telemedicine is a positive instrument to offer hospice care to remotely located patients, there are various barriers that accompany it. Some physicians fear that less skilled practitioners will be used to facilitate telemedicine consultations and that patients might be reluctant to accept this type of care. Legal issues must also be considered concerning medical malpractice and lack of FDA guidelines regarding use of hardware and software in telemedicine systems. There are also concerns regarding rights to patient information, privacy and confidentiality through the use of telemedicine.[146]

Government Oversight of Hospice Services in Maryland

Government oversight of hospice services, including facilities, staff, and program operation is the responsibility of both federal and State agencies. Although this report focuses on the oversight responsibilities of the MHCC, it is important to consider how hospice services are regulated by other government agencies. Listed below is a summary of the primary federal and State agencies that provide oversight at some level or over some aspect of the provision of hospice care in Maryland.

- **Federal Level**

Health Care Financing Administration. HCFA is the federal agency that administers Medicare, Medicaid and the Children's Health Insurance Program. HCFA provides health insurance for over 74 million Americans through Medicare, Medicaid and State Children's Health Insurance program (SCHIP). In addition to providing health insurance, HCFA also performs a number of quality-focused activities, including regulation of laboratory testing, surveys and certification of health care facilities (including hospices), and quality of care improvement.

Office of the Inspector General. The Office of the Inspector General ("OIG") of the Department of Health and Human Services ("HHS") works with HCFA to develop and implement recommendations to correct systemic vulnerabilities detected during OIG/HHS investigations. The OIG believes that an effective compliance program provides a mechanism that brings the public and the private sectors together to reach mutual goals of reducing fraud and abuse, improving the quality of health care services and reducing the cost of health care.[147]

[144] Journal of Telemedicine and Telecare, *A Cost Measurement Study for Home-Based Telehospice Service*, 2000; 6 Suppl 1:S193-5.
[145] Journal of Telemedicine and Telecare , *Hospice Care Using Home-Based Telemedicine Systems*, 1998; 4 Suppl 1:58-9
[146] Highway to Health: Transforming U.S. Health Care in the Information Age: March 1996. Website: http://nii.nist.gov/pubs/coc_hghwy_to_hlth/hii.txt

[147] *Office of Inspector General's Compliance Program Guidance for Hospices*, September 1999, p.3.

- **State Level**

Department of Health and Mental Hygiene. The Department of Health and Mental Hygiene ("DHMH") develops health programs that protect Maryland residents. It is a highly complex organization with a broad scope of responsibility. DHMH is comprised of over 30 program administrations, 24 local health departments, over 20 residential facilities and more than 20 health professional boards and commissions. The Medical Assistance Program ("Medicaid"), which pays for hospice services, is also located within DHMH.

Office of Health Care Quality. The Office of Health Care Quality ("OHCQ"), an administration within DHMH, is mandated by State and federal law to determine compliance with the quality of care and life standards for a variety of health care services and related programs, including hospice services. The agency is responsible for licensing, certifying and/or approving providers who provide care and services. It also investigates quality of care complaints from the general public. The quality of care and compliance with both State and federal regulations in 8,000 health-care facilities and health-related services and programs is monitored by OHCQ. In order to regulate these institutions and programs, the OHCQ conducts more than 10,000 inspections yearly.

Currently, hospice providers must renew their licenses every three years. The initial renewal fee is $300.00. Each year, OHCQ receives guidance from HCFA indicating the percentage of hospices that should be surveyed during the upcoming fiscal year. The percentage is based upon the budget of the Federal government as well as actions in Congress. In Fiscal Year 2000, the figure was 15 percent. In Fiscal Year 2001, the figure is 17 percent which means that each hospice is reviewed approximately every six years.

Although the MHCC maintains a database on home health agencies that are also licensed for hospice services, it currently does not collect complete information from all hospice care programs. A trade association, the Hospice Network of Maryland, conducts a voluntary annual survey of licensed member programs. The Office of Health Care Quality is currently working with the Hospice Network of Maryland to collect information such as characteristics, utilization, and total revenues concerning all hospices in Maryland.

Public Health Administration. The Prevention and Disease Control unit of the Community and Public Health Administration is primarily concerned with the prevention of disease and injury in Maryland through education and preventive health services. The agency sets key goals and objectives concerning Treatment/Supportive Care for cancer support services such as transportation, cancer support groups, case management, and hospice care.[148]

Health Professionals Boards and Commissions. The purpose of the Health Professionals Boards & Commissions is to

[148] MF02.06 Prevention and Disease Control-Community and Public Health Administration.

ensure that the highest quality health care is provided to the residents of Maryland. The Health Professionals Boards & Commissions issues licenses to practice in the State of Maryland. It also investigates complaints and takes disciplinary action against licensees when necessary. Both health professionals and consumer members serve on the boards. Each board follows the ethical guidelines and standards of the profession it regulates. Another function of the Health Professionals Boards & Commissions is to promote knowledge and performance of goals for professionals that concern the citizens of the State of Maryland.

One health occupation board, the Board of Physician Quality Assurance ("BPQA"), is an agency of the State with the authority to license physicians and certain other health care professionals such as physician assistants, cardiac rescue technicians and medical radiation technologists in Maryland. In addition to establishing qualifications for licensure, the BPQA is responsible for investigating complaints against licensed professionals and for taking action against the license of those who violate Maryland's standards of medical care delivery, including care delivered by hospice services.

The missions of other boards, such as the Board of Nursing, the Board of Social Workers, and the Board of Pharmacy are to protect the people of Maryland through licensure, certification, and other regulations governing the scope and details of each health occupation's practices. Since hospice is based on a team approach to deliver care, nurses, social workers and pharmacists are often the primary health-care providers of hospice services**.**

Maryland Department of Aging. The Maryland Department of Aging ("MDOA") oversees the delivery of programs, services and benefits through Maryland's network of 19 local Area Agencies on Aging. The Area Agencies maintain a referral list of hospice facilities in each jurisdiction, and provide information when contacted by consumers. MDOA's Ombudsman Program coordinators act as advocates for residents of nursing homes and its Senior Health Insurance Assistance Program ("SHIP") also offers comprehensive health insurance counseling to older Marylanders and their caregivers.

Office of the Attorney General. The Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General has the authority to handle consumer complaints against hospice providers that involve billing, contractual or reimbursement issues. The Unit refers quality issues to the appropriate licensing agency.

Maryland Health Care Commission. Through its statutory authority and responsibilities under Part II ("Health Planning and Development"), Subtitle 1 ("Health Care Planning and Systems Regulation"), of Article 19 ("Health Care Facilities") of Maryland's Annotated Code, the MHCC is responsible for the development and administration of the State Health Plan.[149] In turn, the State Health

[149] The Comprehensive Standard Health Benefit Plan for Small Businesses established by the Commission includes a hospice benefit equivalent to the services

Plan provides the policies, review standards, and need projections against which applications for Certificate of Need are evaluated. Consequently, the SHP is fundamentally a policy and procedural guidebook for Commission decisions on the establishment and activities of health care providers and services defined by law [150] as "health care facilities" requiring CON review and approval.

Through the CON program, the Commission regulates market entry and, in many cases, exit from the market by these health care facilities, determines whether they may establish or close individual medical services[151], and may review proposals to expand or reduce service capacity.

Market Entry

Since the enactment of the statute creating the former Maryland Health Resources Planning Commission in 1982, hospice care programs (as well as home health agencies) have been included in the definition of "health care facility" for purposes of coverage by CON review requirements. However, since most home health agencies and virtually all hospice programs existing at that time[152] had been created by hospitals or nursing homes as a facility-based medical service, statutory language was added at several junctures over the next several years[153] to clarify that any geographic expansion (beyond their current jurisdictions) by an existing hospice or home health agency required an additional CON. Existing programs of both kinds rushed to be "grandfathered" as these successive additions to Commission and licensing law established additional requirements.[154]

Since Medicare did not include hospice care as a covered service until the 1983 effective date of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, followed by Medicaid's adding the benefit in 1985, relatively few freestanding hospices existed at the time of the 1984 amendments to statute. The imposition of a separate State licensure requirement for hospice programs in 1987 was an indicator of the program's growth, and the increasing

and reimbursement mandated under the Medicare program.

[150] The statute defines "health care facilities" for purposes of CON review at Health-General Article §19-114(e), and delineates the actions by proposed or existing health care facilities that require CON review and approval at §19-123.

[151] A list of the "medical services" regulated by the Commission was added to statute in 1988: "(1) Medicine, surgery, gynecology, addictions; (2) Obstetrics; (3) Pediatrics; (4) Psychiatry; (5) Rehabilitation; (6) Chronic care; (7) Comprehensive care; (8) Extended care; (9) Intermediate care; or (10) Residential treatment; or . . . [a]ny subcategory of the rehabilitation, psychiatry, comprehensive care, or intermediate care categories of health care services for which need is projected in the State health plan." Health-General Article §19-123(a)(4).

[152] I.e., those that provided palliative health care services and skilled nursing as well as grief counseling and spiritual care.

[153] Chapter 681 Acts 1984, Chapter 670, Acts 1987, and Chapters 688 and 767, Acts 1988.

[154] With regard to home health, the 1988 amendment provided that as long as a home health agency established by a facility without a CON between January 1 and July 1, 1984 (the latter being the effective date of a statutory change requiring separate CON approvals for additional agencies, counties, or branch offices) did not exceed $333,000 in annual operating revenue, no CON would be required. Those established (or expanded) prior to January 1, 1984 were also excluded from the impact of this change.

interest of freestanding providers. This new law explicitly stated that, except for a program with a limited license, a person seeking licensure "shall have a certificate of need . . . for the hospice program to be operated."[155]

Uncodified language in the 1987 licensure statute provided that hospice care programs established without CON approval, "in existence and delivering hospice care services before January 1, 1987" that sought State licensure between July 1, 1987 and July 1, 1988 would "not be required to obtain a Certificate of Need prior to licensure." However, those programs "seeking exemption from formal submission of a Certificate of Need" were required to meet criteria to be developed by the Health Resources Planning Commission ("HRPC") with the Hospice Network of Maryland and other interested groups for determining whether the hospice program was existing and operating before January 1, 1987.[156] All hospice care programs that met those requirements wrote to the HRPC for their grandfathering determinations during the designated twelve-month period, or indicated their desire to remain a limited-license hospice.

Another factor in the Commission's regulation of market entry for hospice care services has been its interpretation of key provisions of its statute, regulations, and administrative precedent, and the impact that those interpretations have had on the CON requirement for new hospice care programs.

The first of these determinations resulted from the grandfathering of existing and operating programs that took place after the effective date of the State licensure requirement. Since hospice programs that existed before either the CON or the licensure requirement had no geographic limitation on their service area, once grandfathered, this service area was determined to be statewide. This was reinforced by the argument that since nearly all of these pre-existing hospice programs had been established as medical services within hospitals or nursing homes, which may serve a resident of any Maryland jurisdiction (and in the case of facilities with specialized services, often draw patients from across the state), the determination that their hospice programs had similar geographic scope. Even when, beginning in the early 1990s, corporate tax advantages, changed reimbursement rules, or mergers with other facilities provided incentive to "spin off" facility-based hospice services into a freestanding, though usually still affiliated program, this determination of "statewide authority" to serve patients was found still to apply.

Another determination that affects market entry for new hospice care programs is inherent in the State Health Plan's definition of capacity as the number of programs, its projection of net new need as a number of patients, and considering both on a county-specific basis. Although statutory amendments in 1984 made explicit the requirement for an existing facility or home health agency to obtain additional CON approval for each new home health agency, branch office, or geographic are, and also to separate a branch office and transfer its

[155] Health General Article, §19-906.
[156] Chapter 670, Acts 1987.

ownership to create a new agency,[157] no such explicit language was enacted relating to hospice care programs. In 1988, new statutory provisions explicitly required CON approval for any change in type or scope of health care services resulting in the "establishment of a . . . hospice program," but did not speak directly to a CON requirement for each new geographic area, as does statute relating to home health. However, since its first State Health Plan, covering the years 1983-1988, the Commission has measured hospice capacity and projected hospice need on a county-specific basis. Certificate of Need review has apportioned market entry accordingly. Another exception to the CON requirement for new hospice care programs, and for expanding the service area of an existing program to additional counties, extends to hospice programs operated by health maintenance organizations, *if they are serving their own subscribers*. Both Commission statute and CON procedural regulations state the permission to serve subscribers -- either without CON approval, or without CON approval in a jurisdiction not already CON-approved – in the negative: a CON is required for any "health care project" for which a CON is otherwise required, "if that health care project is planned for or used by any non-subscribers of that health maintenance organization."[158] COMAR 10.24.01.02D(3) requires CON approval for any health care project by an HMO "if that health care project is planned for or could be used by non-subscribers. . ."

The State Health Plan for Long Term Care Services, in its rules governing the threshold for scheduling CON review in jurisdictions where the Plan projects need for new service capacity, places another threshold to market entry in this service. At COMAR 10.24.08.05P, the Plan states that "if the maximum net number of additional hospice clients to be served in a jurisdiction [as calculated by the Plan's need projection formula] is below 250 in the target year, the Commission will not docket an application to provide additional hospice services in that jurisdiction." This threshold reflects the ability of existing hospice programs in a given jurisdiction to increase service capacity by adding direct care staff, and sets 250 net new cases as a point at which the review and approval of a new agency or an expansion of an existing one should be considered.[159]

Need for hospice care programs in the State is projected according to a method in the State Health Plan for Long Term Care Services that describes the assumptions and calculations involved in need projection for all of the long term care services regulated through CON.[160] This methodology was updated in 1997, using a base year of 1997 and a target year of 2001, and more recent population data from the Maryland Office of Planning, cancer death rates based on a three-year average of age-adjusted death rates for 1994-1996 from the Vital Statistics division of the Department of Health and Mental Hygiene, and utilization data from

[157] Health General Article §19-123(j)(3).
[158] Health General Article §19-124(b)(ii).
[159] It is important to note here, however, that an adopted SHP need projection for a out-year target is a ceiling, and does not compel the Commission to approve an otherwise unapproveable application, or, after considering the impact a new agency would have on existing programs, to approve any new capacity.
[160] At COMAR 10.24.08.07.

the Hospice Network of Maryland. The methodology was again updated in 1999, after consideration of several alternative scenarios using different assumptions regarding use rates and factoring in growth of non-cancer deaths and projections to 2002. The hospice need projection basically involves using cancer death rates by age group projected for the target year, and using the hospice death rate in each health service area to derive a jurisdictional hospice use rate. The adjusted minimum use rate is calculated by increasing counties below the 37.5th percentile of all jurisdictions up to that level, and keeping use rates above the 37.5 percentile at their calculated rate. The adjusted maximum use rate is established by setting all use rates that fall below the 50th percentile at the rate of that percentile and setting use rates that fall at or above that percentile at its calculated rate.[161] A projected hospice use rate for the target year can then by calculated, and is expressed as a range between a minimum and maximum rate. The net difference between that projected use rate and the current number of hospice patients (factoring in the projected volume of CON-approved but not yet operating programs) represents the projected need in each jurisdiction.

No projected need for hospice care services remains from the 1999 update of the year 2002 need projection, three existing agencies having been approved by the Commission in May 2000 for expansion into Prince George's County. The State Health Plan excludes from this docketing threshold any jurisdiction served by only one provider; if that sole provider ceases operation--as happened in Caroline County, when on January 2, 1997 the local health department's hospice program closed--then the Commission may review and approve another program regardless of whether the 250-case threshold is met.[162]

Despite the lack of projected need for new hospice care programs, existing providers or would-be new providers may acquire an existing program. Acquisition of an existing and operating health care facility requires only that "the person acquiring the facility or service" to notify the Commission in writing "at least thirty days before closing on any contractual arrangements." This notice must stipulate that no change in capacity or services currently provided will occur as a result of the acquisition, and must also provide information on the previous calendar year's "admissions or visits," and the gross operating revenue from the previous fiscal year. Staff issues a determination of non-coverage by CON review, on its receipt of a complete notice of acquisition. Table 5-6 shows the most recent hospice closures and mergers in Maryland:

[161] This use rate adjustment was made based on analysis of the data.

[162] Commission staff established an interim plan wherein several hospices authorized in contiguous jurisdictions provided services to Caroline Countians, from a referral list supplied to physicians and patients by the county's health department, until January 1998 and the former HRPC's CON approval of Shore Home Care from neighboring Talbot County.

Table 5-6
Hospice Closures and Mergers, Maryland: 1995-2000

Date	Action
March 1995	Northern Chesapeake *acquired* Harford Hospice
April 1995	Merger between Hospices of Memorial Hospital of Cumberland and Sacred Heart Hospital approved with creation of Western Maryland Health System.
December 1996	VNA Hospice of Maryland *acquired* North Chesapeake Hospice
January 1997	Caroline County Health Department *closed* its hospice.
April 1997	Hospice of Frederick County *acquired* Frederick Memorial Hospice
June 1997	Hospice of Baltimore *acquired* Hospice of Howard County
November 1997	VNA Hospice of Maryland *acquired* Hospice of Prince George's County
January 1998	Shore Home Care approved to serve Caroline County.
August 1998	Mid Atlantic *acquired* Hospice of Maryland
October 1998	Bay Area-VNA Merger
October 1998	VNA of Maryland *acquired* Sinai Hospice
January 1999	Upper Chesapeake Home Care *acquired* St. Joseph Medical Center Hospice (and home health)
May 1999	Hospice Foundation of Prince George's County *re-acquired* Hospice of Prince George's from VNA of MD
June 1999	Hospice of St. Mary's *relinquished its license and was acquired* by St. Mary's Hospital.
December 1999	Bon Secours Hospice (and home health) *closed*
February 2000	Heartland Hospice Services (div HCR Manor Care, Ohio) *acquired* Mid-Atlantic Hospice
July 2000 (Completed)	"VNA, Inc." (VNA of DC, which had been a Medlantic affiliate) *assumed operations and statewide authority* of Helix Home Health and Hospice (beginning January 1999)

Source: Maryland Health Care Commission

In order to be granted CON approval by the Commission, a proposed new general hospice care program must demonstrate consistency with the standards for CON review in the Long Term Care Services section of the Plan (COMAR 10.24.08.05 and .06) and address the general review criteria in the CON procedural regulations. The State Health Plan requires an applicant for CON approval as a general hospice care program to provide directly the following services: medical direction, skilled nursing care, counseling or social work and spiritual services. Additionally, a proposed hospice must provide the following services either directly or through contractual arrangements: personal care, volunteer services, bereavement services, pharmacy services, medical supplies and equipment, and special therapies, such as physical therapy occupational therapy, speech therapy and dietary services. Other SHP standards pertain to volunteers, caregivers, financial access by Medicaid enrollees and

persons who cannot pay for care, information to providers and the general public, linkages to other providers, respite care, public education, and prohibition of discriminatory practices.

With regard to inpatient facilities for hospice care – for palliative treatment requiring technology difficult or expensive at home, for respite care, or as a residential placement for someone without family or other informal caregiver – in Maryland there is no separate licensure category, hence no separate CON review, for inpatient hospice beds. (See the discussion under Inventory of Hospice Services above.) When existing community-based hospice care programs or other health care facilities have sought to construct a hospice facility, only the capital expenditure "by or on behalf of a health care facility" is subject to CON review. Hospice of Prince George's County, for example, sought and received CON approval in November 1995 to build a 22-bed hospice facility in 1995[163]. Conversely, Montgomery Hospice Society sought and received a determination in 1992 (a determination reaffirmed in 1998, just prior to the start of construction) that no CON was required for the construction of a hospice facility, because the applicable capital costs did not exceed the Commission's review threshold.

Another means by which an existing hospice care program obtains access to inpatient beds is through contracting with a range of existing inpatient facilities. Northwest Hospital Center recently notified the Commission of an agreement with VNA of Maryland and Mid-Atlantic Hospice to make two hospital-based subacute care beds available for inpatient hospice care, and many nursing facilities across the state also provide this service. Any life safety or quality of care licensure standards applicable to the category of bed used for hospice care remain in effect, and unlicensed beds must still comply with Medicare Conditions of Participation related to the care environment.

Market Exit

Market exit for a hospice care program is far simpler and less process-intensive than establishing or expanding a program. Hospice care programs are permitted to close without CON approval after written notice to the Commission. To require Certificate of *Need* review and approval for the closure of a health care facility or service seems counterintuitive, but the focus of such a review is on the impact of the proposed closure on continued access to the service by the affected population, on the remaining providers of the same service, and on the health care system as a whole.[164]

Maryland Certificate of Need Regulation Compared to Other States

The MHCC commissioned a survey and study, conducted in June and July 2000, to (1) identify current CON regulatory patterns

[163] The CON for the construction of its inpatient facility was relinquished in April 1998 by the not-for-profit Hospice Foundation of Prince George's County during the period in which VNA of Maryland had acquired the clinical and caregiving part of the program.

[164] See *In the Matter of the Closing of Church Nursing Center*, a closure CON approved by the Commission on April 20, 2000.

for hospice and home health services nationwide, (2) document the duration and scope of these regulations and (3) identify and assess the effects of regulatory changes over the last decade and a half on service capacity, use and expenditure levels in selected states. The study was based upon a national survey that included all fifty states and the District of Columbia. The complete report by the contractor, the American Health Planning Association, is available as a separate document.[165]

Currently, 17 states and the District of Columbia regulate hospice development under CON. More than two-thirds of the states regulating hospice development are located in the eastern third of the nation. They are concentrated in the Northeast and the South. While the report addresses no specific explanation regarding concentration in the Northeast and the South, in many states, CON laws were already in place (or efforts to develop them) before there were hospices. Another factor to be considered is that by the time hospice development became an issue in many states, the value of CON regulation itself was being challenged nationally and in many states. As a result, few states added hospice as a covered service after the early 1980s and a number of states discontinued coverage shortly thereafter. Only four states, Kentucky, North Carolina, Tennessee and Maryland extended CON regulation to hospice services after 1980. Hospice services were never included in the CON programs of sixteen states.[166] Three states have imposed a moratorium on new hospice services. Kentucky (which continues to regulate the service by CON), Rhode Island (which eliminated its CON requirement), and Pennsylvania (which had never imposed CON on hospice programs).

From 1991 to 1997, the number of Medicare certified hospices nationwide grew from 951 to 2,327. Following the implementation of the BBA, the figure decreased to 2,290 in 2000 because, as previously stated, under the BBA hospices are required to submit claims for payment for hospice care furnished in an individual's home based upon where care is actually provided. Consequently, the BBA affected the ability of some home health agencies to offer hospice services. As shown in Table 5-7, Maryland had a comparatively large number of hospices (25) in 1991. By 1997, the number had grown by 40 percent to 35.

[165] Maryland Health Care Commission, *Certificate of Need Regulation of Home Health and Hospice Services in the United States*, September 15, 2000.
[166] Ibid.

Table 5-7
Number of Hospices by State CON Regulatory Status: 1991-2000

State/Category	Number of Hospices			Percent Change	
	1991	1997	2000	1991-1997	1997-2000
Continue CON Regulation (N=18)	273	632	617	132%	-2.4%
Eliminate CON Regulation (N=17)	364	835	820	129%	-1.8%
Never Regulated (N=16)	314	860	853	174%	-0.8%
Maryland	**25**	**35**	**31**	**40%**	**-11.4%**
United States	951	2,327	2,290	145%	-1.6%

Source: Maryland Health Care Commission, *Certificate of Need Regulation of Home Health and Hospice Services in the United States*, September 15, 2000.

Although age-specific use rates vary widely across states nationally, approximately two-thirds to three-fourths of those using hospice services are 65 years of age and older. The range in 1997 was extreme, from about 38 patients per 10,000 persons 65 years of age and older in Alaska to nearly 750 per 10,000 in Colorado. With those two exceptions, the range was from about 50 per 10,000 in Maine to approximately 192 in Arizona. As shown below in Table 5-8, use rates by state regulatory status show far less divergence.

Table 5-8
Hospice Use Rates by State CON Regulatory Status: 1991-1997

State/Category	Patients per 10,000 Persons 65 Years of Age and Older		Percent Change
	1991	1997	1997-1997
Continue CON Regulation (N=18)	13.4	96.8	622%
Eliminate CON Regulation (N=17)	13.2	133.0	908%
Never Regulated (N=16)	13.2	109.5	730%
Maryland	**25.1**	**95.6**	**280%**
United States	13.7	116.5	750%

Source: Maryland Health Care Commission, *Certificate of Need Regulation of Home Health and Hospice Services in the United States*, September 15, 2000.

CON regulatory status does not appear to be significantly related to the state use rate. With the elimination of the extreme ranges of Alaska and Colorado, results revealed similar use rate levels across state groupings. Use rates were noticeably higher in Maryland in 1991 than nationally and in most other states, regardless of CON regulatory status. This could reflect the earlier development of the hospice movement in Maryland when compared to other states.[167]

In summary, 18 jurisdictions currently regulate hospice development. Additionally, states that regulate hospice are concentrated in the east, particularly in the northeastern and southeastern states. Of the 33 jurisdictions that do not have CON regulation of hospice development, 16 never instituted coverage. Also, 13 of the 17 that eliminated regulation did so in the 1980s, and four states dropped regulation in the 1990s.[168] In general, hospice development and use patterns in Maryland do not differ much from those found elsewhere.[169]

Alternative Regulatory Strategies: An Examination of Certificate of Need Policy Options

The options discussed in this section represent alternative strategies governing oversight of hospice services in Maryland. The role of government in these options describes a continuum varying from the current role (Option 1), to a more expanded role (Option 2), to an extremely limited role (Option 9). The options below, singly or in combination, represent potential alternative strategies considered by the Commission in conducting this study on CON regulation of hospice services.

Option 1 – Maintain Existing Certificate of Need Regulation

This option would maintain the CON review requirement for new or expanded hospice care programs in current law and regulation. Under current law, establishing a new hospice care program, or expanding an existing program into a jurisdiction not already served, requires a CON. The Commission's decision on a given application is based on its review of a proposed project's consistency with the State Health Plan's review standards and jurisdictional-level need projections, and the general CON review criteria. To exit from this market, only a written notification of the intended closure is required – although Staff often receives its initial notice of a closure from the Office of Health Care Quality that a license has been relinquished or not renewed.

[167] Ibid.
[168] Ibid.
[169] Ibid.

Option 2 – Expand CON Regulation (Require CON for Closure)

Under the current interpretation of health planning statute, no CON has been required for the closure of an existing hospice care program, since the list of "medical services" in §19-123 (a) includes neither hospice nor home health, and the list of "changes in type or scope of services" requiring CON approval does not explicitly include the term "health care facility" used in §19-114 for hospice programs.

One possible option for expanded government oversight of hospice care programs in Maryland would be to intensify the level of CON oversight, by requiring Commission action, through CON or by a finding of CON exemption, on proposed closures. This increased level of scrutiny – which would examine the impact of an impending closure on continued access to hospice services in the affected jurisdictions, and on remaining providers of care – would help the Commission determine whether one program's failure is an isolated event, or a warning of severe stress on the entire provider community. Based on its analysis of the proposed closure, Staff could recommend that the need projections be updated, and schedule a new CON review in the affected county or alternatively, could find that existing hospice programs can absorb the caseload of the closed program.

Option 3 – Retain CON, but Regulate by Region, not Jurisdiction

Although both home health agencies and hospice care programs have been regulated on a jurisdictional level since 1993, when the State Health Plan defined its need projection methodologies consistent with the way the General Assembly clarified the Commission's authority over new and expanded programs, nothing in statute precludes a regional, rather than a county-level need projection. Where the boundaries are drawn, is a matter of regulatory discretion, and may be defined by the Commission in the State Health Plan.

The argument for a regional consideration of applications for community-based services provided largely in the home is one of administrative simplicity, underscored by the fact that geopolitical boundaries and those of health care service areas are frequently non-congruent. Requiring consideration of applications on a jurisdiction-specific basis created a home health review for the Eastern Shore health service area in 1995-1996 where for nine counties, a total of 21 individual CON applications had to be reviewed and analyzed, even though three of the applicants proposed to serve the entire Eastern Shore or large portions of it. This option would retain CON regulation, but conform the Commission's consideration of new or expanded agencies to the way health care services, particularly home- and community-based services, are organized and provided.

Option 4 –Regulate Only Inpatient Hospice Facilities; Deregulate Home-Based Services

This option has been proposed twice in recent years, in bills considered by the General Assembly. HB 1023 of 1998 and HB 717 of 1999 would have changed

"hospice" under the list in statute of entities considered a "health care facility" for purposes of CON regulation to read "hospice facility," and added "a home-based hospice care program" to the list of what is not a "health care facility" and thus not subject to CON review. This approach proceeds from the original purpose of Certificate of Need review, which was to scrutinize very closely any proposed new health care facilities, whose construction costs would likely be subsidized by the public.

It should be noted that under this option, although CON would be partially deregulated, licensure oversight would continue. OHCQ inspects hospices and assesses compliance with Medicare conditions of participation. Licensure could also enforce standards required previously under CON.

Reimbursement for inpatient hospice care continues to be an uneven and situational issue, often dealt with through individual contracts between hospice programs and facilities willing to dedicate beds for patients needing this level of care. Hospitals in Maryland have raised with HSCRC the issue of whether the Commission should set rates for inpatient hospice care. A staff recommendation discussed by the HSCRC at its September 2000 meeting notes that "several Maryland hospices have inquired about the inability of hospitals in Maryland to contract with hospices for general inpatient and respite care at fixed rates based on HCFA's hospice reimbursement as hospitals do in other states." HSCRC's staff position is that it cannot allow hospitals to enter into a "fixed price contract with hospices for hospital services," since that would violate its mandate "to set rates equitably among all purchasers or classes of purchasers." HSCRC staff, while not intending to impede the ability of hospitals to make beds available for hospice patients, is recommending that its Commission not set rates for hospice services in hospitals. HSCRC explains that, because inpatient and respite hospice care are not defined as inpatient hospital services by Medicare, HSCRC does not have authority to get hospital rates for these services. Objections were raised in comments made by the Hospice Network of Maryland and the Association of Maryland Hospitals and Health Systems. HSCRC staff were directed to collect data in order to better understand this issue. HSCRC will continue to examine the issue of hospice rates in the next few months.

Since hospice care programs in Maryland are overwhelmingly community-based, with only four dedicated inpatient facilities and episodic or respite care provided on a case-by-case basis by hospitals and nursing homes, the impact of this option would potentially be similar to that of total deregulation from CON.

Option 5 –Require CON Only in Sole/Two Provider Jurisdictions

Another option is to impose CON review requirements only in jurisdictions with one or two hospice providers, since the addition of another program into a small market has the real potential to destabilize and drive out of business one or both of the existing entities. In the large metropolitan counties, the scale of both geography and population would suggest that new competitors could be more easily absorbed, particularly if ongoing efforts are successful to bring patients into hospice care earlier in their final illnesses.

The Commission already treats these very small markets differently, by waiving the 250-case threshold requirement for considering a new program if a county's sole provider ceases operating. In such a situation three years ago, when Caroline County Health Department announced that it could no longer sustain its hospice care program, the Commission crafted an interim plan wherein any provider in a contiguous county could serve Caroline County clients until a CON review to establish a replacement could be undertaken and completed. This option supports the continuation of CON for entry into these small markets and could also require Commission review of proposed closures.

Option 6 – Deregulate from CON; Create Data Reporting Model

Another option for hospice regulation involves replacing the CON program's requirements governing market entry and exit with a program of mandatory data collection and reporting. Deregulation through elimination of the CON requirement for hospice services is discussed in Option 8, and the implications of that option apply here. Option 6 supports the role of government to provide information in order to promote quality health services. Performance cards, or "report cards" as they have come to be called, are intended to incorporate information about quality into decisions made by both employers and employees in their choice of health plans, and by consumers whose health plans permit a measure of choice in providers. Performance reports can also serve as benchmarks against which providers can measure themselves, and undertake improvements in any quality indicator in which they are found deficient. Report cards can both inform consumer choice and improve the performance of health care providers; how these effects manifest themselves depends on the intended audience.

♦6A – Public Report Card for Consumers for Hospice Services

This option would add a hospice report card to the Commission's growing list of public reports containing basic, service-specific information in a report card style format, promoting consumer education and choice. Hospice report cards could be designed to report on both facilities and community-based services, according to a range of variables including administrative simplicity, availability and expertise of physician medical directors, and accessibility of nurses and other direct care professionals. One potential limitation of the report card approach for hospice care

programs is the importance of subjectively-felt values such as spiritual comfort and care, and of unpaid volunteers, in the hospice way of caring for the dying and their families.

♦6B – Provider Feedback Performance Reports

Under this option, the Commission, or another public or contracted private agency, would establish a data collection and reporting system designed for use by providers. Like the report card option, this involves mandatory collection of detailed outcomes and process information from all hospice services, in order to measure and monitor quality of care using a selected set of quality measures specific to hospice services. The purpose would be to provide feedback on how hospice agencies and caregivers compare to their peers on issues such as staffing and utilization. This option assumes that if providers are fully informed about their performance in relation to their peers, and held more accountable for outcomes of care, they have sufficient incentive to achieve and maintain a level of high quality care. While CON (both historically and as it is now structured) is neither designed nor intended to monitor quality once an approved program begins operation, this option does further that objective.

Option 7 – Expand Department of Aging LTC Ombudsman Program

In Maryland, the Older Americans Act and Maryland law mandate the operation, under the authority of the Department of Aging and implemented by its county-level offices, of the Long Term Care Ombudsman Program. Ombudsman Program Coordinators act as advocates for residents of facility-based long term care services such as nursing homes, assisted living facilities, and adult day care.

Under this option, the responsibilities and authority of the county Ombudsman would be expanded to include community-based services such as home health and hospice. Although progress has been made in establishing community-based service systems, many communities do not yet have the range of programs needed. Ombudsmen would develop a system to investigate complaints and identify system-wide deficiencies at a statewide level. Ombudsmen would protect the rights and personal autonomy of dying patients and their families, and monitor the level of care provided by the hospice care program. This option would require additional funding and staffing for the Ombudsman Program.

Option 8 – Deregulate from CON; Expand Licensure Standards and Oversight

Under this option, the role of government oversight would shift from regulating market entry and exit to monitoring the ongoing performance of providers, through the enhancement of existing licensure standards. Currently, hospices are licensed in Maryland based on compliance with OHCQ standards. Since HCFA only requires that 15-17 percent of a state's hospice programs be inspected each year, unless OHCQ investigated a complaint against a program, each will only be surveyed every six years.

In addition to the quality of care issues traditionally the province of State licensure, coupled with Medicare certification, this stronger licensing program could include and enforce some of the standards reviewed for initial compliance – or stated intent to comply – in current CON review. A commitment to provide an appropriate level of charity care and care for Medicaid recipients, linkages to other community health care providers, ready access to respite care, an active effort at communication and public information – all of these are CON review standards that could be incorporated into a more demanding and active program of State licensure. The necessary strengthening and expanding of licensure under this option might involve adding hospice care programs to the array of home and community-based health care programs that a 1999 legislative proposal would have integrated under a new license category called "community-based health agency."

Subject to limitations of staff resources, this option could require at least the same frequency of inspection as that of nursing homes, which are re-surveyed and re-licensed more frequently. Under this regulatory model, through some series of graduated sanctions, prolonged failure to comply with the requirements of State licensure would ultimately result in the loss of the hospice license as well as Medicare certification.

Option 9 – Deregulate from Certificate of Need Review

♦9A – Deregulation from CON with Moratorium on New or Expanded Services

In a time of severe shortages in direct patient care professionals, from registered nurses to aides to medical technicians, any expansion of a particular sector of the health care market – of capacity or of programs – may be problematic. Volunteers can serve as an important means of extending staff capabilities, but the finite number of volunteers within a given geographic area has often been cited as a reason to deny CON approval to would-be new providers. Removal of restrictions on market entry, whether by CON or other means, raises the possibility that supply will increase. Given that hospice is overwhelmingly a Medicare-paid service and that the death rate from cancer and other hospice-associated diagnoses is fairly predictable, the impact of more providers may be lower case loads for all programs.

The response to this concern in several states that had regulated market entry for hospice care programs through CON has been to repeal CON but impose a moratorium on new or expanded programs.

♦ 9B – Deregulation from Certificate of Need

The effectiveness of Certificate of Need as a means of controlling costs and service capacity, and whether it represents the "best" regulatory tool for the job, has long been debated, particularly with regard to health care services not based in bricks and mortar. The last option, of course, is to deregulate hospice care programs of all kinds from CON review, without the enhanced licensure or information-gathering of the previous options – and monitor the impact of this action.

Table 5-9 summarizes the regulatory options considered by the Commission in conducting the CON program study for hospice services.

Table 5-9
Summary of Regulatory Options for Hospice Care Programs

Options	Level of Government Oversight	Description	Administrative Tool
Option 1 Maintain Existing CON Regulation	No Change in Government Oversight	•Market Entry Regulated by CON •Market Exit Through Notice	Commission Decision: CON approval to create/expand
Option 2 Expanded CON Regulation	Increase Government Oversight	•Market Entry Regulated by CON •Market Exit Through CON	Commission Decision: CON or CON Exemption
Option 3 Retain CON, but Regulate By Region, not Jurisdiction	Change Government Oversight	•Market Entry Regulated by CON For Defined Region •Market Exit Through Notice	Commission Decision: CON to create new regional agency, expand beyond region
Option 4 Regulate Only Inpatient Hospice Facilities; Deregulate Home-Based Services	Change Government Oversight	•Market Entry Regulated by CON, Only if Facility-Based Program •Market Exit Through Notice	Commission Decision: CON for inpatient hospice facilities only
Option 5 Require CON Only in Sole/Two-Provider Jurisdictions	Change Government Oversight	•Market Entry Regulated by CON to Enter Counties with 1 or 2 Programs •Market Exit Through Notice	Commission Decision: CON Only in 1 or 2 Provider Counties
Option 6 Deregulation from CON, Create Data Reporting Model	Change Government Oversight	•No Barrier to Market Entry or Exit	Performance Reports/ Report Cards
Option 7 Expand Department of Aging's LTC Ombudsman Program	Change Government Oversight	•No Barrier to Market Entry or Exit; Monitoring of Care	Potential Sanctions by County Ombudsman for Substandard Care
Option 8 Deregulation from CON, with Expanded Licensure Standards and Oversight	Change Government Oversight	•No Barrier to Market Entry •Sanctions including Market Exit for Non-Compliance with Licensure Rules	Licensure Standards
Option 9 Deregulation from CON, with or without Moratorium	Eliminate All but Present Level of State Licensure, Medicare Certification	•No Barrier to Market Exit •No Additional Programs, if Moratorium Imposed	None

Commission Recommendation

Recommendation 4.0

The Commission should continue its regulatory oversight of hospice services through the Certificate of Need program.

The Commission recommends that the General Assembly maintain existing Certificate of Need regulation for new or expanded hospice services. Among the majority of hospice providers as well as the statewide professional association, a strong consensus exists that it would be preferable to continue oversight of market entry through the CON program. Analysis of utilization data indicates that available hospice services are meeting the needs for end-of-life care in Maryland. Retaining the authority to consider new hospice providers only when additional need warrants will help maintain the stability of this mission-driven, largely non-profit provider network that is heavily dependent on volunteers and community donations. Approval of this recommendation would not preclude the Commission from working with the Department's Office of Health Care Quality to strengthen State licensure requirements for hospice care.